Institute for Integral Health
Dr. Mary Ann Osborne, FNP, DNP
Office 719.632.9969 Fax 719.632.3654

Today's Date: ______________________
Name: _____________________________________ Age: _____ Sex: M. F. DOB_____________
Address: ____
City____ State: _________________ Zip______________
Telephone: Home ___________________ Cell______________________ Work__________________
May we contact you by mail? Y N Phone? Y N Voice Message ok? _________
Email address: ____
Emergency Contact: ____
May we share medical information? ________ If so, Name__________________________________
Current Primary Physician____
Referred by ____

Medical Information

Main Reason for your visit: ____
____
____

Details of any present condition: ____
____
____

Current Medications and Dosages:____
____
____
____

Over the Counter Supplements/Herbs/Vitamins (please be specific)________________________
____
____
____
____

Please Circle anything that applies:

Allergies: No known drug allergies - Penicillin - Sulfa - Codeine - Aspirin - Bee Stings
Food Allergies - Seasonal Allergies - Other:____

+Head, Ears, Eyes, Nose and Throat (HEENT)
Ear pain - Ear infection - Hearing Loss - Tinnitus(ringing in ears) - Dizziness - Vertigo Double vision - Tunnel vision - Glaucoma - Cataracts - Eye pain - Blurriness - Glasses Contacts
Epistaxis (nose bleeds) - Rhinitis (inflammation of mucous membranes that line the nose)
Sinusitis (inflammation of mucous membranes lining facial tissues) - TMJ dysfunction (jaw joint)
Dysphagia (swallowing difficulty) - Vocal cord polyps (lumps) - Dentures - Hoarseness
Sore throat - Neck pain - Neck masses
Other HEENT Problems: ____

Rheumatic:
Systemic lupus - Erythematosus - Rheumatoid Arthritis - Scleroderma - Raynaud's Phenomena
Temporal Arteritis - Other:____

Cardiovascular: Heart
Myocardial infarction (heart attack) - Valvular heart disease (valves to the heart have disease)
Pulmonary hypertension (high pressure in the arteries of the lungs) - Hypertension (high blood pressure)Angina pectoris (chest pain) - Cardiac Arrhythmia (abnormal heart beat or rate)
Congestive heart failure (heart failure) - Carotid stenosis (hardening of the carotid arteries)
PVD-Peripheral vascular disease (narrowing of blood vessels of the legs and arms) Claudication (Limping due to blockage of the arteries of the lower legs)
Other Heart problems:____

Pulmonary:(Lung Problems)
Asthma - Bronchitis Pneumonia - COPD (Chronic Obstructive Pulmonary Lung Disease)
Pulmonary Sarcoidosis - Tuberculosis - Lung pain - Lung masses - Respiratory failure
Cancer - Pneumothorax (presence of air or gas in the lining surrounding the lung causing pain)
Other Lung Problems:____

Gastroenterology: Stomach/abdomen
Frequent; Nausea, emesis, diarrhea or constipation. - Gastroesophageal reflux disease
Peptic ulcer disease - Jaundice (yellowing of the skin and eyes) - Hepatitis (liver inflammation)
Appendicitis (pain and inflammation of the appendix) - Melena (Black stool caused by bleeding)
Colon polyps (masses in the colon) - Diverticulosis/Diverticulitis (protrusions of the bowel)
cholecystitis/Gallstone disease (inflammation or disease of the pancreas)
Other: ____

Kidney: Renal/Urinary
UTI (inflammation of the urinary bladder or urethra) - Prostatitis (inflammation of the prostate)
Kidney failure - Hydronephrosis (fluid filled enlargement of the kidney) - Kidney stones

Cystitis (inflammation of the urinary bladder or urethra) - Polycystic kidney disease
Orchitis (inflammation of one or both testicles) - Vasectomy
BPH (a condition where benign (non-cancerous) nodules enlarge the prostate gland)
Other Renal/Urinary____

Musculoskeletal and Extremities:
Arthritis – Gout - Generalized Muscle weakness - Muscle Weakness - Edema(swelling)
Extremity numbing/tingling/carpal tunnel syndrome
Fractures Y N what body part_____________________________ Left or Right_________
Other: ____

Oncological: (Cancer)
Brain Cancer - Skin Cancer: Melanoma - Squamous cell Carcinoma - Basal Cell Carcinoma
Throat Cancer - Stomach Cancer - Liver Cancer - Pancreatic Cancer - Colon Cancer
Bladder Cancer - Ovarian Cancer - Uterine Cancer - Cervical Cancer - Testicular Cancer
Kidney Cancer - Other:____

Endocrine System: (glands in the body which secrete hormones)
Hypoglycemia (low blood sugar) - IDDM (Insulin dependent diabetes)
Cushing's disease(Excess production of a hormone of the pituitary gland)
Hypothyroidism (not enough thyroid hormones) - Hyperthyroidism (too much thyroid hormone)
Addison's disease (a wasting disease caused by underactive of the adrenal glands)
NIDDM (non-insulin dependent diabetes) Other: ___________________________________

Neurological: (Disease of the nervous system)
CVA-Stroke - TIA Seizure disorder - Migraines - Cluster Headache - Parkinson's Disease
Cranial nerve dysfunction - Other:____

Psychological History: (related to the mind and mental process)
Depression - Anxiety disorder - Mood disorder - Anger disorder - Panic disorder - Dementia
Schizophrenia - Post-traumatic stress disorder - Borderline personality
Other:____

Past Surgical History:

Thyroidectomy _____	Date__________	Bronchoscopy _____	Date_____________
Tonsillectomy _____	Date__________	Lung resection R/L ___	Date_____________
Sigmoidoscopy___	Date__________	Angiogrpaphy____	Date_____________
Valve Replacement____	Date__________	Angioplasty______	Date_____________
Endoscopy______	Date__________	Gastric Surgery___	Date_____________
Pacemaker______	Date__________	Appendectomy_____	Date_____________
D & C____	Date__________		

Total abdominal hysterectomy and removal of ovaries______ Date_____________
Hip replacement _____ R or L________ Date:____________
Other Surgical Procedures and Dates: ____

Family History: **Please tell me mother, father, brother, aunt, uncle, grandparent etc:**

ILLINESS	RELATIONSHIP	ILLINESS	RELATIONSHIP
alcoholism/drug abuse	_______________	Alzheimer's Disease	__________________
asthma	_______________	breast cancer	__________________
cancer (______________)	_______________	depression	__________________
diabetes	_______________	heart attack	__________________
high cholesterol	_______________	high blood pressure	__________________
osteoporosis	_______________	stroke	__________________
thyroid	_______________		

autoimmune disease such as lupus or rheumatoid arthritis _______________________________

Personal History:

Immunizations____ Up to date?__________ HIV Status?_________

Do you smoke tobacco? Y N If yes, how much per day? ______ How many years? _______

Do you smoke marijuana Y N If yes, how much per day? ______ How many Years? ______

Do you drink alcohol? Y N If yes, how many per day/week____________________________

Caffeine intake? Coffee/Tea _____ how many per day_______

How many carbonated drinks per day? _______

Do you use recreational drugs? Y N

If yes, has someone close to you expressed concern regarding your use in drinking or drugs? Y N

Do you feel safe in your home? Y N Do you feel safe in your relationship? Y N

Past diet nutrition and food intake history:

Dietary Education: Self Registered Dietician

Diet Program: Weight watchers - Jenny Craig - South Beach Diet - Atkins - Grapefruit - Paleo

Have you used medication to lose weight? Y N if so, what medications______________________

Are you Gluten Free? Y N if so why____

Are you Dairy Free? Y N if so why____

Have you ever been treated for an eating disorder? Y N

Exercise History:

Do you exercise? Y N

Do you have any conditions that prevent you from exercise? __________________________________

____

What types of exercise do you enjoy? ____

____

How often do you workout per day/per week? ____

Women:

Gynecological:

Dysmenorrhea(painful periods) - Menorrhagia(excessively heavy or prolonged uterine bleeding) Salpingitis (inflammation of the fallopian tubes) - Ovarian cyst – Perimenopause - Premature Menopause/ Surgical Menopause - Post-menopausal G/P - Gravida – Para – Abortions - Miscarriages - Other gynecological:____

History:

Sexual Preference: heterosexual - homosexual - bi-sexual

Age you first menstruated: ________ Date your **last menstrual cycle** begin?___________________

Length of cycle: Every ______days (first day of period (1st day bleeding) to first day of next period).

Do you get cramps? Y N Do you consider them to be: light_____ moderate_____ severe_____

What do you take to relieve them? ________________________

When was your last Pap Smear______________ Results __________________________________

Have you ever had an abnormal Pap Smear? Y N If yes, give date and treatment_____________

____

Do you use birth control Y N what method____________________ How long____________

Have you ever been pregnant: Y N # pregnancies___# births___#miscarriages___# abortions____

Were you depressed after any of your pregnancies? Y N

Today do you need testing for sexually transmitted disease? Y N

Menopause Questionnaire **Please complete if you are experiencing symptoms.**

If you are having menstrual periods, describe any change in frequency, flow, PMS, etc. ___________

____

Have you stopped menstruating? Y N If yes, when?______________

Have you ever had a hysterectomy? Y N If yes, were both ovaries removed? Y N

Have you ever had a mammogram? Y N Date of most recent?____________

Do you notice changes: in your hair or skin? Y N In your memory or mental clarity? Y N

with bladder or bowel control? Y N In your sexuality or sexual response? Y N

in your appetite/weight? Y N How?__________________

Do you experience hot flashes or night sweats? Y N If yes, approximately how often? ________

Have you ever had a test for diabetes or cholesterol?________________________ Y N

How is your sleep? _____________________ Do you find it difficult to get up in the morning? Y N

Do you lack stamina or feel consistently fatigued? Y N

Have you been experiencing anxiety, irritability, depression, anger or tearfulness? Y N

Are those feelings related to a particular stress problem? Y N

Are you experiencing shortness of breath, chest pain or a rapid heartbeat? Y N

Do you notice an increase in generalized body or muscle aches? Y N

Are you experiencing vaginal irritation or infection symptoms? Y N

Is intercourse or urination painful? Y N

Do you have a history or family history of osteoporosis, hip fractures or loss of height? Y N

Have you experienced recent changes in your health or general sense of well-being? Y N

Explain____